ciaries who have a capitated health care plan which covers dental services are not issued a Medi-Cal card.

If non-emergency services are necessary in conjunction with dental services provided for a capitated health care plan enrollee, the dentist must obtain prior authorization for the medical services from the health care plan. Typically, such medical services take the form of in-patient hospital admission or prescriptions for post-dental care.

In medical emergencies, where the required services cannot be delayed and the health care plan cannot be contacted in advance, prior authorization is not required. However, the dentist must contact the health care plan as soon as possible and must fully document the emergency when billing the plan for the services provided.

Capitated health care plans include Primary Case Care Management (PCCM) contractors, county-wide health systems (such as Health Plan of San Mateo and Santa Barbara Health Initiative), the Redwood Health Foundations (covering beneficiaries in Sonoma, Lake and Mendocino counties), and most Prepaid Health Care Plans (PHPs) which furnish coverage for their enrollees and assume the cost of most medical services provided for them. Most of these plans exclude dental benefits. In that case, covered dental procedures may be billed to Denti-Cal.

To contact a particular capitated health care plan, refer to the information given on the beneficiary's enrollment/identification card or consult your telephone directory. You may also telephone the Department of Health Services Office of Medi-Cal Dental Services at (916) 464-3888 for assistance.

Payment Policies

Payment made by Denti-Cal in accordance with the guidelines of the California Medi-Cal Dental Program must be accepted by the provider as payment in full for covered services. It is a violation of state and federal regulations to charge a Medi-Cal beneficiary any additional fee for covered dental services.

Denti-Cal will only pay for the lowest cost procedure that will correct the dental problem. For example, Denti-Cal cannot allow a porcelain crown when a restoration would correct the dental problem. A dental office cannot charge Denti-Cal more than it charges a private patient for the services performed. The dental office should list its usual and customary fee when filling out the claim, TAR or NOA.

For tax purposes, Denti-Cal uses Form 1099 to report earnings to the Internal Revenue Service (IRS) for each billing provider who has received payment from Denti-Cal during the year. Federal law requires that Denti-Cal mail 1099 forms by January 31 of each year to reflect earnings from January 1 through December 31 of the previous year.

It is the provider's responsibility to make certain that Denti-Cal has the correct billing provider name, address and taxpayer identification number (TIN) or Social Security number (SSN) that correspond exactly to the information the IRS has on file. If this information does not correspond exactly, Denti-Cal is required by law to apply a 31 percent withholding to all future payments made to the billing provider. To verify how your tax information is registered with the IRS, please refer to the preprinted label on IRS Form 941, "Employer's Quarterly Federal Tax Return," or any other IRS-certified document. You may also contact the IRS to verify how your business name and TIN or SSN are recorded.

If you do not receive your 1099 form, or if your tax or earnings information is incorrect, please contact Denti-Cal at (800) 423-0507 for the appropriate procedures for reissuing a correct 1099 form.

Time Limitation for Billing

Time limitations for billing services provided under the California Medi-Cal Dental Program are governed by Section 14115 of the Welfare and Institutions Code. Denti-Cal must receive a claim no later than six calendar months after the end of the month in which the service was performed to consider the claim for full payment (100 percent of the SMA). Claims received within six to nine months after the end of the month in which the service was performed will be considered for payment at 75 percent of the SMA amount. Claims received ten to twelve months after the end of the month in which the service was performed will be considered for payment at 50 percent of the SMA amount. The time limitation for billing will be applied to each date of service.